Prepared by John Nakashima, Ph.D., MSW
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CHALENG 2005 Survey: VAMC Chillicothe, OH - 538

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 75

2. Estimated Number of Veterans who are Chronically Homeless: 15

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 75 (estimated number of homeless veterans in service area) **x chronically homeless rate (20 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	145	50
Transitional Housing Beds	26	100
Permanent Housing Beds	10	50

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 1

3. CHALENG Point of Contact Action Plan for FY 2005

Immediate shelter	We will continue to work with continuums and community partners to identify resources for this need. Two Continuums have applied for HUD Shelter Plus Care funding.
Long-term, permanent housing	Work with continuums to develop resource list.
Transitional living facility or halfway house	Encourage community partners to apply for Grant and Per Diem.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **17** **Non-VA staff Participants: 58.8%**
Homeless/Formerly Homeless: **29.4%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.41	7.0%	3.47
Food	3.71	13.0%	3.80
Clothing	3.76	.0%	3.61
Emergency (immediate) shelter	3.81	40.0%	3.33
Halfway house or transitional living facility	3.31	20.0%	3.07
Long-term, permanent housing	2.87	53.0%	2.49
Detoxification from substances	3.53	7.0%	3.41
Treatment for substance abuse	3.65	7.0%	3.55
Services for emotional or psychiatric problems	3.5	7.0%	3.46
Treatment for dual diagnosis	3.3	.0%	3.30
Family counseling	3.12	.0%	2.99
Medical services	4.12	27.0%	3.78
Women's health care	3.21	.0%	3.23
Help with medication	3.41	7.0%	3.46
Drop-in center or day program	2.56	7.0%	2.98
AIDS/HIV testing/counseling	3.69	.0%	3.51
TB testing	4.06	.0%	3.71
TB treatment	3.94	.0%	3.57
Hepatitis C testing	4.00	7.0%	3.63
Dental care	2.71	13.0%	2.59
Eye care	2.82	7.0%	2.88
Glasses	2.59	7.0%	2.88
VA disability/pension	3.50	.0%	3.40
Welfare payments	2.63	.0%	3.03
SSI/SSD process	2.69	7.0%	3.10
Guardianship (financial)	2.81	.0%	2.85
Help managing money	2.94	.0%	2.87
Job training	2.87	20.0%	3.02
Help with finding a job or getting employment	3.47	20.0%	3.14
Help getting needed documents or identification	3.47	.0%	3.28
Help with transportation	3.18	6.0%	3.02
Education	2.75	.0%	3.00
Child care	2.57	7.0%	2.45
Legal assistance	2.35	7.0%	2.71
Discharge upgrade	2.93	.0%	3.00
Spiritual	3.81	.0%	3.36
Re-entry services for incarcerated veterans	2.57	7.0%	2.72
Elder Healthcare	3.33	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.33
Co-location of Services - Services from the VA and your agency provided in one location.	1.00
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.67
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.67
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.67
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.33
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.00
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.00
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.00
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2.00
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.00
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.33

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.00
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	2.57

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CHALENG 2005 Survey: VAMC Cincinnati, OH - 539 (Ft. Thomas, KY)

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 200

2. Estimated Number of Veterans who are Chronically Homeless: 52

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 200 (estimated number of homeless veterans in service area) **x chronically homeless rate (26 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	500	85
Transitional Housing Beds	230	60
Permanent Housing Beds	75	25

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Our HUD/VASH program is working on receiving an additional 20 HUD vouchers for permanent housing. Also, one of our GPD providers is in the process of acquiring funding for supportive housing units.
Medical Services	Our VA just recently entered into a collaborative agreement with a major urban shelter and other healthcare providers such as Cincinnati Health Department and UC medical outreach. We just signed an MOU and in the next few months will be remodeling space.
Immediate shelter	Currently, one of our major shelters does not admit new people on the weekends. We are working with them to change this policy so it would improve access.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **19** **Non-VA staff Participants: 100.0%**
Homeless/Formerly Homeless: **5.3%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.26	.0%	3.47
Food	3.50	5.0%	3.80
Clothing	3.32	5.0%	3.61
Emergency (immediate) shelter	3.05	32.0%	3.33
Halfway house or transitional living facility	2.68	11.0%	3.07
Long-term, permanent housing	2.16	53.0%	2.49
Detoxification from substances	3.00	11.0%	3.41
Treatment for substance abuse	3.26	11.0%	3.55
Services for emotional or psychiatric problems	3.4	5.0%	3.46
Treatment for dual diagnosis	3.6	5.0%	3.30
Family counseling	2.94	11.0%	2.99
Medical services	3.68	21.0%	3.78
Women's health care	3.17	21.0%	3.23
Help with medication	3.28	.0%	3.46
Drop-in center or day program	3.37	.0%	2.98
AIDS/HIV testing/counseling	3.47	5.0%	3.51
TB testing	3.58	5.0%	3.71
TB treatment	3.58	5.0%	3.57
Hepatitis C testing	3.47	.0%	3.63
Dental care	2.47	5.0%	2.59
Eye care	2.42	.0%	2.88
Glasses	2.42	5.0%	2.88
VA disability/pension	2.89	.0%	3.40
Welfare payments	2.53	5.0%	3.03
SSI/SSD process	2.53	16.0%	3.10
Guardianship (financial)	2.21	11.0%	2.85
Help managing money	2.42	5.0%	2.87
Job training	2.89	5.0%	3.02
Help with finding a job or getting employment	2.79	21.0%	3.14
Help getting needed documents or identification	2.63	5.0%	3.28
Help with transportation	2.84	5.0%	3.02
Education	2.58	.0%	3.00
Child care	2.26	5.0%	2.45
Legal assistance	2.42	.0%	2.71
Discharge upgrade	2.16	.0%	3.00
Spiritual	2.74	.0%	3.36
Re-entry services for incarcerated veterans	2.16	5.0%	2.72
Elder Healthcare	2.84	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.47
Co-location of Services - Services from the VA and your agency provided in one location.	1.89
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.53
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.37
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.16
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.74
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.58
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.42
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.16
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.47
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.74
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.89

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.63
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.72

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CHALENG 2005 Survey: VAMC Cleveland, OH - 541, (Brecksville, OH)

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 823

2. Estimated Number of Veterans who are Chronically Homeless: 230

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 823 (estimated number of homeless veterans in service area) **x chronically homeless rate (28 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	700	150
Transitional Housing Beds	989	0
Permanent Housing Beds	850	400

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 27

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Cleveland continues to develop "Housing First" Initiatives throughout the city. A development agency is collaborating with social service providers, business leaders, funders and advocates.
Help finding a job or getting employment	VA CWT Program to focus on Supported Employment Initiative. CWT and local VOA HVRP Collaboration.
Re-entry services for incarcerated veterans	Build partnerships with local halfway houses who have grants to focus on ex-offenders.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **37** **Non-VA staff Participants: 83.8%**
Homeless/Formerly Homeless: **24.3%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.83	.0%	3.47
Food	3.97	20.0%	3.80
Clothing	3.72	3.0%	3.61
Emergency (immediate) shelter	3.81	20.0%	3.33
Halfway house or transitional living facility	3.54	13.0%	3.07
Long-term, permanent housing	2.53	52.0%	2.49
Detoxification from substances	3.78	7.0%	3.41
Treatment for substance abuse	4.03	10.0%	3.55
Services for emotional or psychiatric problems	3.8	7.0%	3.46
Treatment for dual diagnosis	3.8	10.0%	3.30
Family counseling	3.36	7.0%	2.99
Medical services	4.03	7.0%	3.78
Women's health care	3.58	.0%	3.23
Help with medication	3.75	7.0%	3.46
Drop-in center or day program	3.42	3.0%	2.98
AIDS/HIV testing/counseling	4.11	.0%	3.51
TB testing	4.03	.0%	3.71
TB treatment	4.03	.0%	3.57
Hepatitis C testing	3.94	.0%	3.63
Dental care	3.14	10.0%	2.59
Eye care	3.42	3.0%	2.88
Glasses	3.42	3.0%	2.88
VA disability/pension	3.69	13.0%	3.40
Welfare payments	3.16	7.0%	3.03
SSI/SSD process	3.51	3.0%	3.10
Guardianship (financial)	3.56	3.0%	2.85
Help managing money	3.41	3.0%	2.87
Job training	3.31	17.0%	3.02
Help with finding a job or getting employment	3.17	19.0%	3.14
Help getting needed documents or identification	3.44	7.0%	3.28
Help with transportation	3.47	6.0%	3.02
Education	3.36	13.0%	3.00
Child care	2.87	.0%	2.45
Legal assistance	3.09	20.0%	2.71
Discharge upgrade	3.36	.0%	3.00
Spiritual	3.76	7.0%	3.36
Re-entry services for incarcerated veterans	3.14	6.0%	2.72
Elder Healthcare	3.50	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.69
Co-location of Services - Services from the VA and your agency provided in one location.	2.14
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.00
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.76
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.62
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.69
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.72
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.34
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.00
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.59
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.59
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.79

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.97
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.97

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CHALENG 2005 Survey: VAMC Dayton, OH - 552

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 100

2. Estimated Number of Veterans who are Chronically Homeless: 15

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 100 (estimated number of homeless veterans in service area) **x chronically homeless rate (15 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	185	36
Transitional Housing Beds	93	80
Permanent Housing Beds	25	50

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 3

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Emergency housing coalition members will be encouraged to apply for available grants.
Transitional living facility or halfway house	Encourage community agencies to apply for housing grants.
Other	Need: reintegration of sexual offenders. This will be discussed at Emergency Housing Coalition meetings. It is extremely difficult to find jobs and housing for sexual offenders.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **18** **Non-VA staff Participants: 76.5%**
Homeless/Formerly Homeless: **5.6%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.69	.0%	3.47
Food	3.94	.0%	3.80
Clothing	3.50	.0%	3.61
Emergency (immediate) shelter	3.20	13.0%	3.33
Halfway house or transitional living facility	2.56	47.0%	3.07
Long-term, permanent housing	2.19	53.0%	2.49
Detoxification from substances	3.13	7.0%	3.41
Treatment for substance abuse	3.38	.0%	3.55
Services for emotional or psychiatric problems	3.4	20.0%	3.46
Treatment for dual diagnosis	3.2	7.0%	3.30
Family counseling	3.06	.0%	2.99
Medical services	3.75	7.0%	3.78
Women's health care	3.13	.0%	3.23
Help with medication	3.31	.0%	3.46
Drop-in center or day program	3.33	.0%	2.98
AIDS/HIV testing/counseling	3.47	.0%	3.51
TB testing	3.38	.0%	3.71
TB treatment	3.31	.0%	3.57
Hepatitis C testing	3.31	.0%	3.63
Dental care	2.75	.0%	2.59
Eye care	2.69	.0%	2.88
Glasses	2.81	.0%	2.88
VA disability/pension	3.38	.0%	3.40
Welfare payments	2.81	.0%	3.03
SSI/SSD process	2.47	20.0%	3.10
Guardianship (financial)	2.43	.0%	2.85
Help managing money	2.43	7.0%	2.87
Job training	3.31	.0%	3.02
Help with finding a job or getting employment	3.19	27.0%	3.14
Help getting needed documents or identification	3.19	.0%	3.28
Help with transportation	2.69	13.0%	3.02
Education	2.88	7.0%	3.00
Child care	2.67	.0%	2.45
Legal assistance	2.44	13.0%	2.71
Discharge upgrade	2.81	.0%	3.00
Spiritual	3.33	13.0%	3.36
Re-entry services for incarcerated veterans	2.38	13.0%	2.72
Elder Healthcare	2.75	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.38
Co-location of Services - Services from the VA and your agency provided in one location.	2.08
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.92
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.31
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.85
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.54
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.85
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.23
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.69
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.62
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.69
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.69

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.75
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.36

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAOPC Columbus, OH - 757, (Grove City, OH)

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 500

2. Estimated Number of Veterans who are Chronically Homeless: 145

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 500 (estimated number of homeless veterans in service area) **x chronically homeless rate (29 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	210	100
Transitional Housing Beds	24	50
Permanent Housing Beds	30	100

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 10

3. CHALENG Point of Contact Action Plan for FY 2005

Immediate shelter	New partnerships will be formed by using the HUD shelter list. Emphasis will be placed on forming partnerships with the new YWCA family shelter to increase immediate shelter for homeless veterans with children.
Transitional living facility or halfway house	Community agencies will be encouraged to apply for Notice of Funds Available. HCHV staff will continue to forward the notices and attempt to forge new partnerships to increase transitional living in the community.
Long-term, permanent housing	HCHV will continue to work with community agency partners and landlords to increase affordable long-term permanent housing for homeless veterans. Subsidized housing has significantly decreased over the past year.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **18** **Non-VA staff Participants: 93.8%**
Homeless/Formerly Homeless: **11.1%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.35	.0%	3.47
Food	3.56	24.0%	3.80
Clothing	4.11	6.0%	3.61
Emergency (immediate) shelter	2.35	65.0%	3.33
Halfway house or transitional living facility	2.44	41.0%	3.07
Long-term, permanent housing	2.35	41.0%	2.49
Detoxification from substances	3.39	.0%	3.41
Treatment for substance abuse	3.53	6.0%	3.55
Services for emotional or psychiatric problems	3.4	12.0%	3.46
Treatment for dual diagnosis	3.5	.0%	3.30
Family counseling	3.22	.0%	2.99
Medical services	3.78	18.0%	3.78
Women's health care	3.33	.0%	3.23
Help with medication	3.35	6.0%	3.46
Drop-in center or day program	2.67	6.0%	2.98
AIDS/HIV testing/counseling	3.39	.0%	3.51
TB testing	3.78	.0%	3.71
TB treatment	3.72	.0%	3.57
Hepatitis C testing	3.59	.0%	3.63
Dental care	2.78	.0%	2.59
Eye care	3.35	.0%	2.88
Glasses	3.41	.0%	2.88
VA disability/pension	3.56	6.0%	3.40
Welfare payments	3.28	.0%	3.03
SSI/SSD process	3.29	.0%	3.10
Guardianship (financial)	2.89	.0%	2.85
Help managing money	2.89	12.0%	2.87
Job training	3.11	24.0%	3.02
Help with finding a job or getting employment	3.06	18.0%	3.14
Help getting needed documents or identification	3.18	.0%	3.28
Help with transportation	3.06	.0%	3.02
Education	2.78	.0%	3.00
Child care	2.94	.0%	2.45
Legal assistance	3.11	.0%	2.71
Discharge upgrade	3.11	.0%	3.00
Spiritual	3.39	.0%	3.36
Re-entry services for incarcerated veterans	2.17	29.0%	2.72
Elder Healthcare	3.22	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
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Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.77
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.15

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.60
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.73